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Medical Education in Time of National Emergency

A Statement by

THE JOINT COMMITTEE ON MEDICAL EDUCATION IN TIME OF NATIONAL EMERGENCY

Representing

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

and

THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS
of the
AMERICAN MEDICAL ASSOCIATION

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The mounting tension of the times confronts medical education with great responsibilities. Only physicians trained as highly as the state of medical knowledge and available resources will permit can serve the national interest well, whether this be in a military or in a civilian capacity. In full recognition of the need of both the armed forces and the civilian population for good medical care, as many well trained physicians as possible should be produced. To accomplish this aim in time of emergency, the following proposals are offered by THE JOINT COMMITTEE ON MEDICAL EDUCATION IN TIME OF NATIONAL EMERGENCY, which represents the Executive Council of the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association. These proposals have been formulated in order to profit from the experience of World War II, to avoid a repetition of the mistakes made then, and to attempt to prevent the occurrence of new errors.

The duration of the emergency on which we have entered, and of the policy of limited mobilization are at this time quite unknown. The longer or more serious the emergency, the greater will be the demand for physicians —for well trained physicians. One of the hard lessons learned from the medical training program employed in World War II was that in the national interest demands for speed and quantity should never be permitted to interfere with quality.

It is, consequently, especially important that no steps be taken at the beginning of the present emergency that will interfere with the adequate training of physicians either as medical students or as interns and residents, or with the supply of properly trained basic scientists. If, as now appears probable, the emergency bids fair to be prolonged over many years, we must exercise great

care that, in instituting measures necessary to meet the pressing and immediate demands of the emergency, we do not interfere with the continuous training of physicians. Such training requires an uninterrupted supply of students through college into and through medical school and hospitals; it requires a smaller but vitally important supply of graduate students in the basic and clinical sciences; and, it requires, also, the maintenance of an adequate basic science, as well as clinical faculty. It requires continuation of the principles of individual student participation and instruction which are basic to good medical education and which would be vitiated by acceleration, overcrowding of students or loss of faculty to the point where attention to the individual student would be diminished.

At a time when the armed forces and the civilian population both at home and abroad are demanding doctors, it is the responsibility of the medical schools to outline the conditions necessary in a critical period to the adequate training of doctors so that they will best be able to serve society. These proposals attempt to outline these conditions as they apply in a time of national emergency.

Depending on the degree of emergency, three possible methods of organization of our socieity might be instituted:

1. Partial Mobilization
    a. Limited mobilization (as in effect now)
    b. Extensive mobilization (as in World War II)
2. Total Mobilization (as under a National Service Act)

The primary emphasis in the proposals which follow is on policies and procedures in periods of *Partial*—and not of *Total*—mobilization. Should total mobilization be adopted as a national policy, students, faculty and physicians would then be assigned to civilian or military duty or to study, teaching or research. This would probably remove the stigma from those not in military service and not wearing a uniform. It is, however, our earnest hope that adequate mobilization of national resources and manpower can be achieved without the necessity of resource to total controls. The proposals herewith submitted are, however, adapted to a program of total mobilization, should this be imposed.

Whether or not the country is engaged in waging war, it is probable that a state of national emergency will be long lasting. Since well trained physicians will continue to be required, the provisions necessary to guarantee the quality of their training will apply to the problems of recovery and reconstruction following cessation of military activities, quite as much as they do in a time of immediate emergency. Problems relating to transition from a time of emergency to a state of peace will be studied by the Joint Committee when some pictures of the conditions likely to be prevailing at that time becomes visible. The medical profession and the medical schools stand ready to make all adjustments needed to meet the emergency. Medical schools, hospitals and other civilian institutions should study carefully the problem of utilizing personnel with maximum efficiency in the discharge of their responsibilities to the nation and should be prepared, whenever necessary to redefine in the light of these

studies, their needs for medical manpower. The governmental services should likewise continually reexamine their utilization of medical manpower to the end that an expanded military establishment will not impair the health of the nation by unnecessarily disrupting the training of physicians or widely or irregularly withdrawing doctors from the care of the civilian population.

Since physicians trained by the medical schools, universities and hospitals are as essential to the government as are the graduates from the military service schools, it is encumbent upon the Federal Government to guard the integrity of medical education in time of emergency, as in time of peace. The need for hasty mobilization occasioned by the Korean war has led to irregularly extensive withdrawals of professional personnel, a process which should be controlled now by the immediate utilization of central and local committees empowered to adjudicate national and local questions of availability and essentiality of medical manpower.

PROPOSALS

1. *Deferment of Preprofessional College Students.*

A procedure for deferment of preprofessional college students in the field of medicine, dentistry, veterinary medicine and osteopathy is provided by Selective Service Local Board Memorandum No. 7. A broader plan for deferment of college students in all fields of study has been recommended to General Hershey by the five Scientific Advisory Committees to the Selective Service System and by the Healing Arts Educational Advisory Committee of the Selective Service System has been approved by him in principle but still under study and has not been adopted as official policy. This plan is based upon: (a) the standing of students in the freshman and subsequent years of college and (b) a scholastic aptitude test. This test should be administered by a nationally recognized testing service, such as the Educational Testing Service of Princeton, New Jersey. This broader plan is enthusiastically endorsed by the Joint Committee. The Committee urges prompt adoption and implementation of this plan. The Joint Committee is not favorable to the policy of identification and selection by medical schools of college students as "premedical students" early in their college careers, which appears to be implied in the following sentence in the new law for induction of medical, dental and allied specialists:

"It is the sense of the Congress that the President shall provide for the annual deferment from training and service under this title of numbers of optometry students and premedical, preosteopathic, preveterinary, preoptometry and predental students at least equal to the numbers of male optometry, premedical, preosteopathic, preveterinary, preoptometry and predental students in attendance at colleges and universities in the United States at the present levels, as determined by the Director."

The Joint Committee recommends that students desiring to study medicine be included in the broad deferment plan for college students mentioned above.

2. *Duration of College Training.*

So long as the national circumstances permit the basic structure of collegiate education to continue undisturbed, four years of college training prior to entrance into medical school are desirable. In an emergency requiring extensive mobilization, the period of college training prior to entrance into medical school could be reduced to ninety semester hours, contained in three academic years of college training. This would involve 90-110 weeks of actual study.

The curriculum for those planning to enter medicine should be kept flexible during the college period. The emphasis should be on developing the students' capacities and attitudes quite as well as on installing specific scientific knowledge. The student must continue to demonstrate superior performance in the courses that are regularly required for admission to medical school.

3. *Selection of Medical Students.*

The selection of all medical students, and we believe, of all professional students, should be in the hands of the individual professional schools, for only in this way is it possible to secure the candidates for medical study. The period for accepting applications and commencing and concluding the acceptance of medical students should be as uniform as possible.

Qualified individuals on active duty who secure permission from the Armed Forces, Public Health Service or Veteran's Administration to apply for admission to medical school should be eligible for consideration with other candidates for admission. If accepted for admission, we believe that such students should be placed on inactitve duty during the period of medical training, including undergraduate and graduate phases. During this training, they could wear special identifying insignia.

A satisfactory mechanism for the deferment of medical students who are registrants with the Selective Service System is provided at present by Local Board Memorandum No. 7.

On the basis of experience with the AST and V-12 programs in World War II, we believe very strongly that it is neither desirable to place medical students in uniform nor to have them subsidized as a group by the government. It might be wise to have a special insignia which could be worn by the students to indicate that they have been deferred, or if commissioned, placed on an inactive duty status, for study considered essential to the health and welfare of the nation.

In place of such induction and full payment of medical students as was conducted under the AST and V-12 programs in World War II, we believe consideration should be given to the inauguration of a system of governmental scholarships which would be available to students on the basis of economic need or as a reward for academic superiority. A program providing government loans should also be considered. The medical schools should be charged with the responsibility of selecting the recipients of these scholarships or loans.

Medical schools should, of course, continue to accept properly qualified

female students and properly qualified male students who may be physically unacceptable to the Armed Services.

4. *Obligation of Medical Students to Serve Their Country Following Graduation.*

The status of students and their obligation to serve will, it is recognized, depend upon national circumstances. A plan should be devised which will define clearly the obligation of students who have been deferred for professional study to serve the government subsequent to completion of their training. *Deferment* should not indicate *exemption* from government service, but merely *delay or postponment* of service. Students deferred by the Selective Service System should on completion of hospital or other graduate training and on certification of availability by such appropriate agencies as the National Advisory Committee on the Selection of Doctors, Dentists, and Allied Specialists to the Selective System and the Health Resources Advisory Committee to the National Security Resources Board be obligated over a period of years to serve when needed in such federal services as the Armed Forces, Public Health Service or Veteran's Administration hospital program for a period consistent with the obligation of others for military service. The certification of availability referred to above should be made after consideration of the civilian, public health and welfare needs, including essential research and teaching. Deferment, therefore, has as its only objective a later service in a needed capacity.

As this problem is being studied by appropriate government agencies, representatives of the medical schools and the medical profession should participate in the formulation of policies.

5. *The Medical School Curriculum.*

The continuous 36 month accelerated program in the medical schools during World War II was almost universally recognized as a major cause of production of poorly trained doctors. It was exhausting to students and faculty alike and developed immature physicians. Such a program of acceleration could not be reinstated in the present emergency without very serious disruption of the training of physicians, not only for the reasons stated above, but also because at least one-third of the medical schools have now extended one or more of their academic years from 9 months to 10, 11 or 12 months. This is because the extension of knowledge has made it appropriate for some schools to increase the length of their basic science years and because many schools have found it necessary to utilize an 11 or 12 month third or fourth year, or both, in order to provide adequate training in public health, psychiatry and other newly emphasized disciplines. Indeed only by using their clinical facilities over this extended period have a number of schools found it possible to provide an adequate training in medicine and surgery and other clinical subjects.

For the majority of medical schools the committee recommends as an essential during an extensive emergency or war that the curriculum extend over four

12 month years. This would permit continuation of the program already under way in many schools. It would also provide opportunity for inclusion during extended academic years of special periods of new material essential for national welfare and security, especially in time of emergency. Studies of atomic energy, radiation sickness and protection, blast injury, bacteriological and chemical warfare, the handling of mass casualties and other aspects of civilian defense, special problems in epidemiology, industrial medicine and hygiene, rehabilitation and utilization of manpower, military medicine, tropical medicine and needed military procedures would be included. Consideration by the Joint Committee of the content of such studies is under way in consultation with representatives of the Surgeon General of the Public Health Service, the Director of Medical Services, office of the Secretary of Defense, the Surgeons General of each of the Armed Forces, the Chief Medical Director of the Veterans Administration, the Director of the Health Resources office of the National Security Resources Board, the Medical Schools and the Medical Film Institute. It is already clear that some of the material can be integrated into the existing curriculum; it is equally clear that new time, new courses, new teachers must be found if medical students are to be trained adequately in these important areas.

During a period of extensive mobilization, it is probable that students will not be deferred during long summer vacations. If the college year ends in June, medical schools operating under the proposed four 12 month year curriculum might, therefore, be expected to begin in July. Students would then graduate from medical school in June at the end of four 12 month years. As long, however, as vacation is permitted after completion of college, and medical schools continue to commence in September, three 12 month and one 9 month years are recommended. The few schools which elect to operate on an accelerated program should, of course, be free to continue to do so. In any of these programs, summer vacation periods, normally three months in length, could be limited to one month at the end of the freshman year and either one month or two weeks at the end of the second and third years, the remaining two weeks being inserted at the end of quarters or semeters during the school year.

Many schools would doubtless wish to incorporate much of the new material into their regular courses or clerkships, extended in length. Others might wish to devote two month periods either in the summer or between quarters or semesters to special study given either by their own faculty or perhaps by representatives of governmental agencies. During such periods in schools where R. O. T. C. programs are in effect, students could be sent to a camp or a clerkship in a military hospital. In such periods some groups might be sent to special centers or schools for instruction in atomic medicine or civilian defense. Some schools operating on an accelerated program might wish to place such special instruction at the end of the established academic program. The final program should be that which in the judgment of each school is most consistent with its program of maintenance of high standards of medical educa-

tion and the promotion of the public welfare. At the end of such a four year program, graduating physicians would be more mature, better trained in their profession and also have basic training in matters of public health, civilian defense and military medicine. When in addition, they complete their hospital and graduate training, they should be prepared for duty necessary to the national health, safety and welfare without the necessity of preliminary orientation, even after entrance into active military duty.

6. *Number of Students in Medical School.*

Since the end of World War II the medical schools, by expanding their facilities and faculties, have been able to increase the number of students admitted annually from a prewar average of 6000 to over 7000. It is recognized that in an emergency of any duration a further increase in production of physicians will be necessary. Since most medical schools are today maximally expanded and some even over-expanded, it is clear that, in order to produce more physicians, they will need more faculties and facilities. To accomplish this would require additional funds and additional teachers. It is clearly the obligation of each school to explore anew its resources with a view to determining, if possible, how and to what extent it can increase its output without lowering quality and what it will require to do so.

It should be obvious that the depletion of existing faculty through service in Armed Forces of significant numbers of active teachers, including graduate students and hospital residents, such as occurred in World War II, would not only reducce the quality of present teaching but would work in direct opposition to any program for increasing the supply of physicians. Such depletion might, indeed, necessitate a reduction in enrollment in medical schools.

7. *Faculty Requirements.*

The maintenance of adequate faculties is essential if medical schools in a national emergency are to meet the demands placed on them for the education of medical students, the advanced training of physicians, basic scientists, investigators, and new teachers; for the prosecution of research important to the national health, safety and welfare; and for the training of ancillary personnel in the health services.

To maintain the faculties of medical schools at proper strength for the accomplishment of these objectives, it is imperative that there be established without delay an effective, coordinated and enlightened program regulating the entrance into military duty, both on a voluntary and on an involuntary basis, of those who constitute the faculties of the medical schools. This program should be so designed that the stigma of evasion will not be attached to those deferred for essential activities related to medical education. It is urged that the National Advisory Committee on the Selection of Doctors, Dentists and Allied Specialists to the Selective Service System and the Health Resources Advisory Committee to the National Security Resources Board formulate without delay, for the guidance of local advisory committees, principles and policies

governing this important phase of the selection and distribution of physicians between the civilian population and the armed services.

The actual selection of individuals at all levels, in conformity with these principles and policies, should reside in local communities, organizations and institutions; so far as education is concerned in medical schools and teaching hospitals. It is strongly urged that the local committees in areas in which medical schools are located include the deans of such schools or their representatives. The educational institutions, with which this statement is particularly concerned, should be directed to assess and report not only their minimum needs for continuing operation, but also their capacity to expand and the requirements for such expansion without deterioration of quality of education.

The minimum faculty essential for the conduct of a satisfactory program of medical education must be carefully safeguarded and maintained. This minimum will vary from medical school to medical school and will depend on many factors such as the size of the school and its other responsibilities for research, for medical service and for the teaching of groups other than undergraduate medical students, e.g. graduate students, practicing physicians and students in other colleges of the university of which the medical school is a part.

This minimum number of essential teachers obviously must be related to the size of the normal peacetime faculty of the medical school, e.g. some medical schools can release very few faculty members without seriously handicapping their teaching program while other medical schools, particularly those with relatively larger faculties, can release more without deterioration in the quality of their instructional programs. On the other hand certain schools ought to add faculty members.

Local and state advisory committees to the Selective Service System should be required to discover the needs of the individual medical schools for faculty members both for undergraduate medical student instruction and for the other essential activities carried out by the medical schools and to make adequate allowance for these needs.

In time of limited or extensive mobilization the problem of faculty morale is a difficult one. Essential teachers who are liable for military service must either be deferred or inducted and assigned on inactive duty to the medical school. There are, however, those among the faculty who are unwilling to be declared essential. Some of these might be appointed consultants to military hospitals in the vicinity so that they may be of service from time to time on a temporary duty status. Some may be allowed to enter service. For these, however, the period of active duty should be for a clearly limited period of time, such as two years, after which they should be returned to the faculty. In their military assignment consideration should be given to their technical knowledge and skills and their ability to teach. In their place on the faculty, substitutes or exchanges might be released from active service. Such exchanges should be equivalent both as to function and competence. Such a rotation of faculty members while, of course, easier to implement in the clinical than in

the basic science fields, and while presenting some problems in the development of sustained and continuing programs of instruction, would be preferable to the loss of key faculty members for tours of duty lasting four, five or more years. Perhaps a similar scheme of rotation between civilian and military duty could be extended to many practicing physicians.

Such arrangements for rotation would seem to offer great advantages in terms of (1) supply (2) morale (3) professional ability of medical officers and faculty alike. If faculty members on active duty had the opportunity to return to the medical schools for teaching, study and research, their incentive and skill would be increased. Likewise their presence in the schools would be of great value in the training of students in the meaning and the value of military training.

The maintenance of a continuous supply of new faculty members is as great a need as is the continuous supply of premedical and medical students. This is true both for basic science and clinical faculty.

8. *Graduate Students in the Basic Medical Sciences.*

To maintain the flow of basic science faculty, graduate students in the basic sciences, both in college and medical school must be deferred for study, teaching and research. The failure to do this in World War II produced a severe shortage in supply of basic science preclinical faculty, a shortage from which we will suffer and which would be seriously exaggerated if a more intelligent policy were not put into effect in the present emergency.

It is imperative that this need be kept in mind by the National Advisory Committee on the Selection of Doctors, Dentists and Allied Specialists to the Selective Service System and the Health Resources Advisory Committee to the National Security Resources Board, and by local advisory committees. It may be easier for local committees to understand the community needs for medical practitioners and even for hospital residents than for graduate and postgraduate students and basic science faculty. It is, therefore, essential that clear instructions be issued so that the significant part that men in these areas play in the production of qualified physicians is fairly evaluated and clearly understood.

9. *Interns.*

All internships should be at least 12 months in length. When feasible in light of the needs, some longer internships should be permitted. The nine month internships during World War II were universally recognized as unsatisfactory. All medical school graduates should be permitted an internship or equivalent training as graduate or postgraduate students. Interns and graduate students should be selected by the hospitals and medical schools as in peacetime.

10. *Residents.*

Residency training is a form of postgraduate education without which it is impossible to produce a continuing flow of competent teachers, clinical investigators and specialists. These residents are essential to adequate patient care

in the better hospitals. Furthermore these residents constitute one of the largest and most helpful group of teachers and research workers.

It is recognized that a national emergency with is immediate demands for men will result in some limitation of residency training. It cannot be too strongly emphasized, however, that no matter how serious the emergency may become, there will always be urgent need for a program that provides for the continuous training of residents.

During World War II a percentage of residents were deferred for 9-18 months of residency. Because, however, residents completing even a full "9-9-9" experience were insufficiently trained to justify the temporary loss in medical manpower entailed in their residency training, the nine months residency in World War II was unsatisfactory. The saving in time under the "9-9-9" program proved to be false economy.

It is now recognized that internship and residency training are as integral parts of the training of a physician as is his undergraduate medical course. Consequently a policy of indiscriminant issuance of commissions to residents who volunteer for service (under Public Law 779), without possibility of deferment to meet essential situations, would be shortsighted. Its general application might mean that, for all practical purposes, next year there would be no residents. Even if a policy of return of officers from active duty to undertake residency training is undertaken, it may be two or three years before such officers are returned. There will be a serious break in the chain of residency training. This will interrupt the training of specialists important alike to the Armed Forces and to the civilian population and will disrupt the clinical clerkship teaching of medical students.

It is recognized that opportunities for residency training should be available to properly qualified individuals who have been in active service; and that following one or two years of hospital training after graduation from medical school, many young physicians could be expected to serve on active military duty for a suitable period before returning to undertake or to complete residency training. This program should not, however, be permitted to interfere with a policy of deferment of selected junior as well as senior residents for proper training in teaching hospitals. This policy should become the immediate responsibility of the National Advisory Committee on the Selection of Doctors, Dentists and Allied Specialists to the Selective Service System and the Health Resources Advisory Committee to the National Security Resources Board who should so advise each local advisory committee so that the presently threatened disruption of the residency training program can be brought under control.

11. *Medical Education under University Military Training or a National Service Act Involving Total Mobilization.*

No extensive discussion is attempted here of the effect of a Universal Military Training Program or of a National Service Act upon medical education. It is felt such a discussion should be deferred until more specific information is available concerning such programs or the possibility of their develop-

ment. It must be clear, however, that even under U. M. T. or a National Service Act adequate provision must be made for a continuing flow of premedical and other science students, medical students, interns, residents and graduate students in the basic sciences and for retention of adequate faculty to supply the necessary training. The proposals which have been submitted in this report are, it is believed, readily adaptable to conditions of full mobilization under a National Service Act.

In any universal military training program which might be adopted, provision should be made for a delay in the period of required service of qualified preprofessional college students until they have completed their college and professional training or have discontinued the program. This plan should employ the principles recommended earlier in this document for the deferment of outstanding college students under the present Selective Service Act. Such students would thus be able to serve society and their government later in their special needed capacity. They should not be called upon to perform double duty for the armed forces.

Summary

1. To insure the continued production of well qualified medical graduates, provision must be made for an adequate supply of premedical students.

2. The duration of premedical study should not be reduced below 90 semester hours, the equivalent of 3 academic years.

3. All medical students should be selected by the medical schools.

4. Subsequent to graduation and internship, deferred medical students should, if certified as available by such appropriate agencies as the National Advisory Committee on the Selection of Doctors, Dentists and Allied Specialists to the Selective Service System and the Health Resources Advisory Committee to the National Security Resources Board, be obligated to serve when needed in the Armed Forces or other specified government services.

5. The curriculum of medical study should be reorganized to give proper emphasis to subjects of particular importance for the national health, security and welfare in time of national emergency.

6. Medical schools should exert every effort to admit as many medical students as they can train without deterioration of the quality of medical training they can provide. Provision should be made for the increased financial support essential to the provision and maintenance of the increase in faculty, facilities and buildings required to accomplish the proposed increase in enrollments.

7. The maintenance and replenishment of adequate faculties in the medical schools are absolutely essential to the continuing production of well trained physicians to meet the needs of the civilian population and Armed Forces.

8. All medical school graduates should have an internship or graduate or postgraduate training of twelve or more months' duration.

9. The continuation of an active residency training program is essential

to adequate professional training, teaching and medical care, even in the gravest emergency.

10. Provision for training of young men in the basic medical sciences, including graduate training, is also essential for the teaching and research functions of the medical schools and for the prosecution of research programs elsewhere. Properly qualified personnel, whether they do or do not hold a degree in medicine, should be deferred or assigned to these activities rather than to active military duty.

Conclusion

In time of emergency, just as in time of peace, an important phase of national security—the maintenance of health—demands highly trained physicians in sufficient numbers. The objective of the present proposals is the maintenance of this supply of physicians. These proposals reflect the critical and intensive thinking of medical educators who since World War II have been studying this problem so as to benefit from the experience and mistakes of World War II. They have been developed after full opportunity to obtain the suggestions of representatives of the governmental agencies concerned. These experiences, and consequently these proposals, emphasize the fundamental truth that in medicine there can be no substitute for adequate training. It is urged, therefore, that in the best interest of the nation this principle be recognized fully in all plans for medical education that may be adopted in the present or future emergencies.

JOINT COMMITTEE ON MEDICAL EDUCATION IN TIME OF NATIONAL EMERGENCY

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